DOCUMENT RESUME

ED 332 419 EC 300 281

AUTHOR Mason, James L.; Young, Thomas M., III
TITLE Therapeutic Case Advocacy Workers' Handbook. Therapeutic Case Advocacy Project.
INSTITUTION Portland State Univ., OR. Research and Training Center on Family Support and Children's Mental Health.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, MD.; National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE Jun 90
CONTRACT G0087C0222-88
NOTE 46p.; For a related document, see EC 300 282.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Agency Cooperation; Change Strategies; *Child Advocacy; *Delivery Systems; *Emotional Disturbances; Group Dynamics; Group Structure; Interdisciplinary Approach; Intervention; Models; Program Evaluation; Program Implementation; Teamwork
IDENTIFIERS *Case Management

ABSTRACT

This training guide is intended as an aid for agencies and professionals in creating interagency efforts to provide comprehensive care to children and youth with serious emotional disorders and their families. It is not a generic concept but a specific approach to providing care. Section I addresses the key assumptions that undergird the model, concerning child characteristics, viewing emotional disorders as disabilities, service needs, and systems of care. Section II discusses the roles and structures associated with the application of the concept of therapeutic case advocacy task groups. Section III outlines the components the model uses to affect changes in environments, systems, or people's behavior. These components include case advocacy, interpersonal intervention, and care management. Each component is guided by certain principles of action and a cluster of skills which are identified. Section IV addresses group process issues that must be acknowledged. Section V examines some basic evaluation concerns. (Three references) (JDD)

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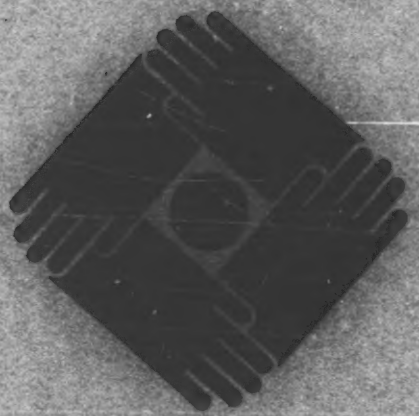
Therapeutic Case Advocacy Workers' Handbook



Therapeutic Case Advocacy Project
Research and Training Center on Family Support
and Children's Mental Health
Portland State University

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EC 300 281

Therapeutic Case Advocacy
Workers' Handbook

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June 1990

The recommended citation of this publication is:

Mason, J.L. & Young, T.M. (1990). *Therapeutic Case Advocacy Workers' Handbook.* Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

This publication was developed with funding from the National Institute on Disability and Rehabilitation Research, United States Department of Education, and the National Institute of Mental Health, United States Department of Health and Human Services (NIDRR grant number G0087C0222-88). The content of this publication does not necessarily reflect the views or policies of the funding agencies.

ACKNOWLEDGEMENTS

The creation of this training guide has been a collaborative effort of many individuals and agencies. Two Therapeutic Case Advocacy work groups were established to staff cases and plan service delivery within the Multnomah County office of the Oregon Children's Services Division. Project staff are deeply indebted to agency administrators and unit managers, namely: Linda Sunday, June Anderson, and Sarah Claiborne. In particular, the contributions of Ms. Anderson's and Ms. Claiborne's unit were indispensable to the development of this guide.

The Portland Research and Training Center's National Advisory Committee was also helpful in the development of the concept, its application, and the training materials. The project's local advisory panel was instrumental in demystifying the barriers between agencies and systems and between formal and informal support networks.

I would personally like to acknowledge the contributions of TCA project members: Thomas M. Young, Principal Investigator, and Kathryn Yoakum, Project Associate, for their enormous help in the project and in creating project materials. Perhaps most of all, I must acknowledge Dr. Jane Knitzer, who initially coined the phrase, Therapeutic Case Advocacy and who inspired our interest in this concept. I would also like to acknowledge the many people and agencies demonstrating the usefulness of the concept through using a collaborative and coordinated approach to serving children and youth with serious emotional disorders and their families.

James L. Mason, Manager
Therapeutic Case Advocacy Project

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INTRODUCTION

This training guide is intended as an aid for agencies and professionals in creating interagency efforts to provide comprehensive care to children and youth with serious emotional disorders and their families. It is not a generic concept, but a specific approach to providing care.

While the approaches vary, the constant has to be the creation of case level systems of care that involve a variety of providers, both formal and informal, to meet the needs of the child and family. This approach to serving children and youth has been supported by practice and research, yet it is still easier said than done. Undoubtedly, the key is to identify a structure or framework that relates to policy and is not a reflection of a worker's or supervisor's whim, caprice, or personality. When the concept is used by practitioners but is not supported by policy, the concept may not survive the strains of budget crunches, scrambles for resources and interagency rivalries and turf issues.

This document is a fairly linear progression through some key issues concerned with the concept and its application. Section I addresses the key assumptions that undergird the model. Section II discusses the roles and structures associated with the application of the concept. Section III includes the components the model uses to affect changes in environments, systems, or people's behavior. Each component is guided by certain principles of action and a cluster of skills which are identified. Section IV addresses the often overlooked area of group process issues that must be implemented and acknowledged if a task group is to remain viable over time and which ultimately directs and manages the interaction between diverse individuals engaged in difficult work. Section V examines some basic evaluation concerns. Even though evaluation may be short changed in light of restricted budgets it is indispensable to the iterative process of model development and program implementation.

This guide is supported by a Trainer's Guide, and (1) three bibliographies that cover case advocacy, treatment approaches, and interagency collaboration; (2) an article by the Principal Investigator, Thomas M. Young, III, Ph.D., describing the concept; and (3) the final report of the project's activities.

SECTION I: THE BASIC ASSUMPTIONS

CHARACTERISTICS OF CHILDREN AND YOUTH WITH EMOTIONAL DISABILITIES

The TCA model has been developed for use with children and youth with serious emotional disabilities and their families. Definitions of this population vary across localities and service systems. The model makes use of the definition developed by the Child and Adolescent Service System Program (CASSP) and is organized around four variables: age, diagnosis, disability, and duration. These criteria are outlined below:

1. **Age**: eighteen years old or younger, except in systems that serve youth to age twenty-one;

2. **Diagnosis**: one of the following DSM III diagnoses:

   - pervasive developmental disorder (including autism)
   - childhood schizophrenia (including children with mental retardation who have psychotic symptoms)
   - schizophrenia of adult type, manifested in adolescence
   - severe behavior disorders (conduct disorders) requiring 24-hour care and supervision
   - other childhood disorders requiring care for one year or more and resulting in substantial functional limitations in at least two areas of disability specified in DSM III;

3. **Disability**: substantial functional limitations of major life activities in two or more of the following areas:

   - self care (at an appropriate developmental level)
   - perception and expression
   - learning
   - self direction (behavior, judgment, values)
   - family life; and

4. **Duration**: the disability must have occurred for more than one year, or the specific diagnosis must indicate continued disability for more than one year.

VIEWING EMOTIONAL DISORDERS AS DISABILITIES

The DSM III is a classification scheme identifying a range of mental disorders; many of these disorders may affect the emotions and mental processes of children and youth. Under TCA, the emotional and behavioral consequences of these disorders become "disabling" when the child is expected to function in an environment that does not consider their capabilities.

This perspective asserts that children and youth with emotional disabilities are similar to people with physical disabilities; if environmental conditions are inappropriate, the child's ability to perform is limited by the environment. Specifically, "emotional disturbance" may be viewed more productively as an affective and behavioral reaction of the child to the expectations, instructions, supports and rewards in his or her environment.

This perspective implies that all behavior settings within the child's environment must be assessed for how the child is instructed, supported and rewarded and the ways in which this accommodates the particular emotional disability. Settings can be modified to be compatible with the child's capabilities. These changes collectively produce a system of care at the case level that is specific to the child and their environment.

TCA is a model for creating changes to establish such a system of care. The model replaces the child-as-problem perspective with one that stresses the environment-as-solution. This is accomplished by assembling a system of care tailored to meet the capabilities and needs of each child and family.

SERVICE NEEDS

The Child and Adolescent Service System Program (CASSP) has described the types of services most often needed by children and youth with serious emotional disabilities and their families. In addition, CASSP has identified key characteristics of the process of providing these services, such as:

1. utilizing the multi-agency approach for multi-problem clients;
2. collaborating with parents and families in all aspects of treatment planning and service delivery;
3. coordinating collaboration between multiple providers;
4. making optimal use of community-based resources and natural networks of support; and
5. recognizing the individuality of these children and youth and the importance of respecting cultural, ethnic, racial, economic and geographic factors when planning and delivering services.

SYSTEMS OF CARE

The ultimate goal of TCA is to establish individualized case-level systems of care for children and youth with emotional disabilities and their families. This goal stems from the belief that most of these children have difficulty in a variety of behavior settings. Therefore, professionals from agencies involved with the child should understand and respect the collaborative goal, in addition to their own agency's

goal. The combined goal involves creating a system of care that encompasses all aspects of the child's environment and requires modified expectations, instructions, supports and rewards. Those in collaboration should confirm that they:

1. will operate under the same information;

2. will share information and continue to seek ways to facilitate agreements and working relationships;

3. will develop a service or treatment plan based on mutual agreement; and,

4. will be consistent in their expectations of the child and in providing instruction, support and reward.

This collaboration establishes the necessary foundation for the system of care and influences the way professionals, agencies, children and families will work together in the future.

Systems of care distribute the responsibility of providing service among an array of providers, both formal and informal. Services are identified to meet specific treatment needs and to offer normalizing experiences for the child.

By distributing responsibility for the system of care among an array of providers, TCA has an immediate impact at the interagency level. Individual workers are freed from the onus of trying to meet client's needs in isolation from other workers and professionals. This redistribution of effort occurs simultaneously with activities, to ensure that service delivery is coordinated, individualized and comprehensive.

SYSTEM OF CARE ELEMENTS

Certain resources and services needed by children and youth with emotional disabilities can be viewed as "generic" elements. Since these generic elements will be contained in almost every system of care, it is important to establish linkages with providers as early in the process as possible. A partial list of the generic elements will address such areas as:

- education
- children's mental health
- child welfare
- juvenile justice
- youth employment
- parent support groups
- religious organizations
- respite and childcare
- (special) recreation
- crisis intervention
- drug and alcohol
- dental and health care
- housing
- youth development

Support and access to providers of these services is crucial in planning and developing resources.

Individualized systems of care will have elements particular to a given child (e.g., Grandma Jones as a source of respite, a neighbor who agrees to provide transportation to and from school, a Big Brother/Sister to provide companionship for a child, etc.). These case-specific needs cannot be anticipated, but will emerge through the case presentation or problem-solving aspects of the TCA model. Case-specific resources are personal and often add a sense of belonging to the child's and family's life.

TCA does not purport to predict the element a child will need. However, the on-going process of establishing linkages with providers or potential providers must occur prior to serving clients. With such linkages established, energy can be directed toward developing case-specific resources or services as needed.

In some ways, the system of care can be inhibiting. Too often, our imaginations are limited to our experiences, or our creative problem-solving activities and service delivery efforts do not go beyond a given system of care. In such cases it is important to identify or imagine the services that could benefit the child and family, instead of providing services that are easy to obtain.

Another issue involves the use of natural support networks. Although this approach has become basic in working with clients of color, it should also be considered for children and families of the dominant culture. Natural supports may be individuals (e.g., close friends, neighbors, priests, ministers, rabbis, herbalists, midwives) or organizations in a given community (e.g., churches, temples, synagogues, Kiwanis, Elks, Masons, human and civil rights groups, advocacy organizations and self help groups). These resources are often overlooked and may be difficult to identify in a given community. Natural support networks help to extend limited resources and involve more people in the care and treatment of children and their families.

SECTION II: THE STRUCTURE OF THERAPEUTIC CASE ADVOCACY TASK GROUPS

INTRODUCTION

Goals TCA coordinates the efforts of a variety of individuals and agencies working on behalf of children and youth with serious emotional disabilities and their families. This is accomplished by establishing collaborative task units that:

1. develop service plans to include individualized, client-centered systems of care for children and youth with serious emotional disabilities;

2. engage the family in the treatment planning and service delivery processes;

3. coordinate the actions of service providers;

4. provide a structure for inter-agency treatment planning, problem solving, decision making, and conflict management; and

5. identify and develop formal and informal resources for the case-level system of care.

Levels of Intervention TCA is a multi-level model to improve planning and service delivery at three different levels:

1. The *case level* includes service providers and professionals from formal agencies and organizations, members of the family's natural networks of support, the extended family and significant others;

2. The *organizational level* includes staff from a particular agency, system, or governmental body that can affect internal policy or practice to enhance service delivery or remove barriers to service delivery; and

3. The *inter-agency level* includes representatives from key service systems, agencies, and organizations that serve children and youth with serious emotional disabilities and their families, (e.g. mental health, special education, child welfare, juvenile justice, etc.)

The action plan and the levels to be addressed are identified by a child's collaborative task group and specified in the treatment plan. For example, it may be important at the case level for a special education instructor to reconfigure a child's set of expectations, instructions, supports, and rewards to reflect the child's abilities and limitations. At the organizational level, the special education instructor would need the agency's sanction and support to modify the school environment. At the inter-agency level, the special education instructor's modifications must be supported by and be consistent with all behavioral settings in which the child engages. (See Figure 1.)

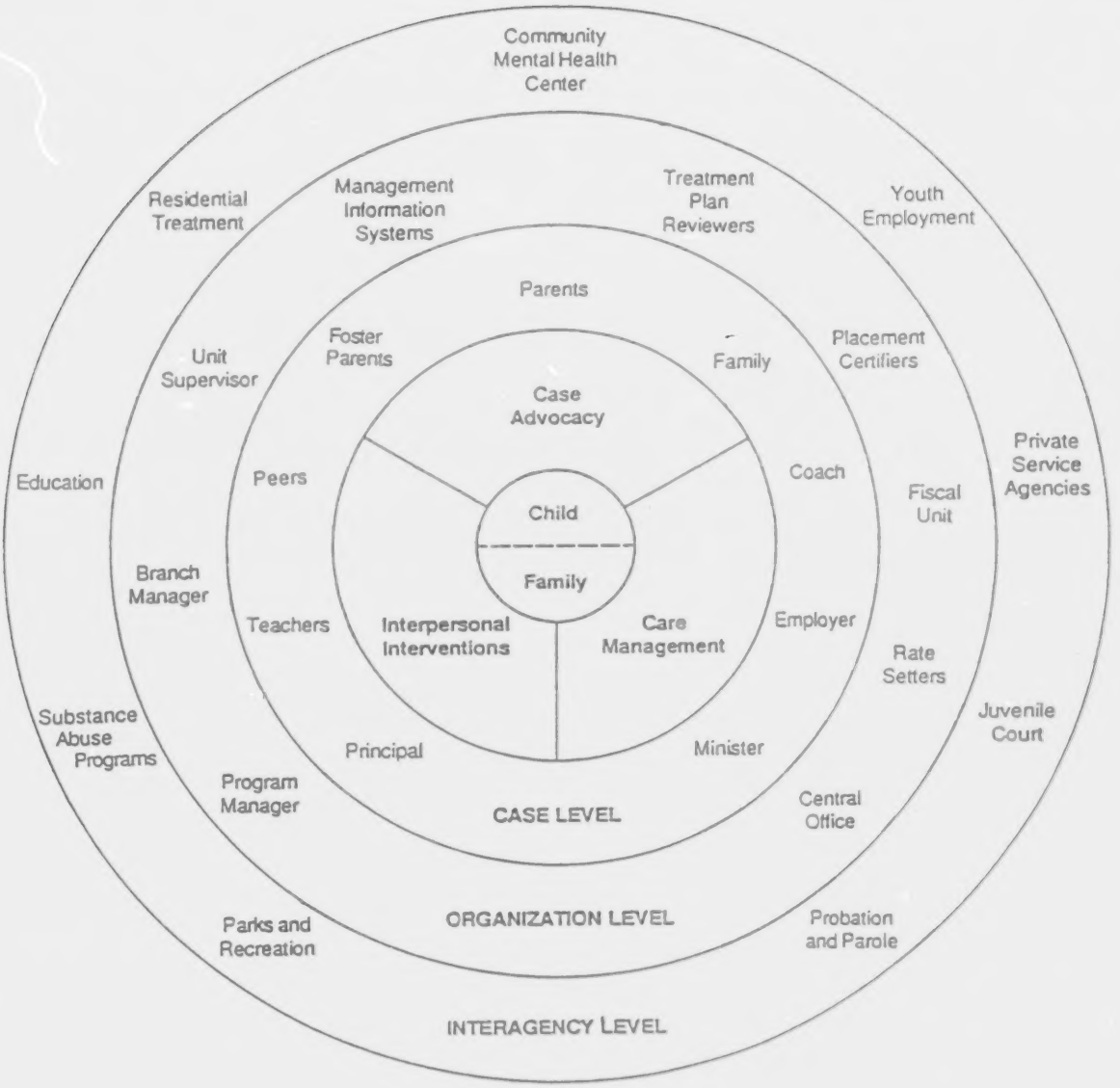
Community Mental Health Center
Residential Treatment
Management Information Systems
Treatment Plan Reviewers
Youth Employment
Parents
Foster Parents
Family
Placement Certifiers
Unit Supervisor
Case Advocacy
Private Service Agencies
Education
Peers
Coach
Fiscal Unit
Child
Family
Branch Manager
Teachers
Interpersonal Interventions
Care Management
Employer
Rate Setters
Substance Abuse Programs
Juvenile Court
Principal
Minister
Program Manager
CASE LEVEL
Central Office
Parks and Recreation
ORGANIZATION LEVEL
Probation and Parole
INTERAGENCY LEVEL

FIGURE 1

13

The issue is for all providers and interventions to be consistent regarding a specific child. The agency must allow the worker the latitude or freedom to participate collaboratively regarding the child. Information must be exchanged in a timely and honest fashion to allow collaboration. Agency policies or practices present barriers that preclude effective inter-agency collaboration and coordination must be identified and overcome.

FORMATS FOR IMPLEMENTATION

TCA is performed in either a "lead-agency" or an "inter-agency" format. (See Figure 2.) Under the *inter-agency* approach, workers and professionals representing several key agencies collaborate to plan and deliver mental health treatment. Parents are involved in the treatment planning and the service delivery processes. This inter-agency group may serve children and youth from participating agencies or serve as a consulting and treatment-planning body for a given catchment area.

Under the inter-agency approach several steps are crucial:

1. Agency administrators must agree to cooperate. Cooperative agreements must be developed, as well as forms for releasing information. Often this is as easy as having agency attorneys contact each other.

2. One worker must be selected to participate on a regular basis. This worker may be involved in both treatment planning and service delivery; however, the former is of primary concern.

3. The format and protocol for meetings must be outlined to specify meeting logistics, group leaders/facilitators and recorders, involvement of parents or family members, and development of group process policies and guidelines.

4. The process of developing resources and utilizing formal and informal providers must occur. The issue of outreach is particularly important in view of the variety of agencies, community groups, and individuals who can provide resources to children and their families.

The *lead-agency* approach refers to a collaborative body that is convened by one agency. This "lead" organization assumes administrative responsibility for the group. Under this format, personnel from within an agency form an in-house group to plan and deliver comprehensive mental health treatment. This group also includes parents in all aspects of treatment planning and service delivery.

The lead-agency approach involves several steps prior to staffing the case:

1. Convene agency staff and managers to apprise them of the new approach. In large agencies, the various unit managers should agree to cooperate and support the TCA unit. It would be dangerous to presume that barriers do not exist within agencies, or that coordination of agency resources or services is a guarantee.

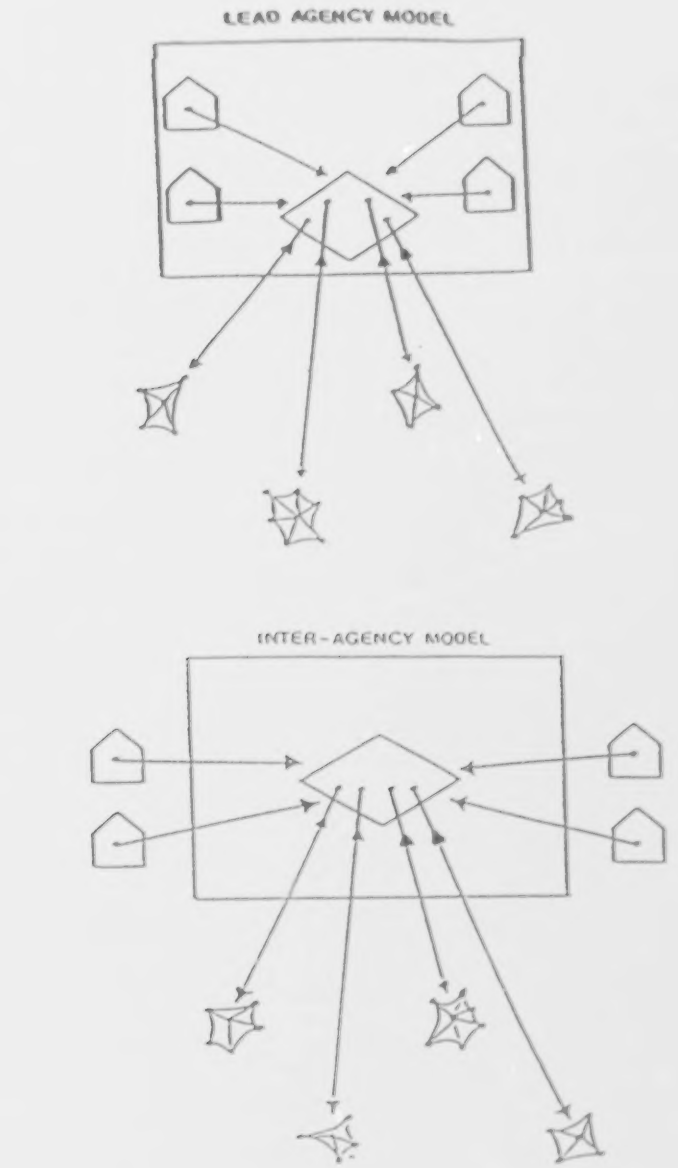

Figure 2
Formats for Implementation

2. Workers must be supported in their efforts. Often TCA workers must meet parents, conduct family or environmental assessments, develop resources and contacts, or directly deliver services. The worker must be free to secure community involvement.

3. Workers will be equally involved in treatment planning and service delivery, so protocol must be developed and specified for both efforts.

4. Cooperative agreements must be developed with major providers (e.g., public schools, special education, juvenile justice, crisis centers, respite providers, support and self-help groups, etc.). A list must be prepared of natural helpers and community-based organizations that are under- or untapped resources.

5. Internal case or class advocacy must be conducted in a way that does not jeopardize worker or agency integrity. Similarly, the approach for conducting external case or class advocacy must promote positive relationships between agencies.

6. Consider ways of measuring the impact of TCA upon the agency, workers, children and families, and upon collaborating agencies.

Under either approach, TCA involves two task groups: (1) the planning unit and (2) the service team. The *planning unit* is primarily responsible for developing initial service plans to identify elements (i.e., resources and services) to be included in a case level system of care. The *service team* is essentially the case-level system of care for a particular child. The service team will have direct contact with the child and will be aware of their situation, progress and setbacks on a timely basis.

Both task groups need to work in a complementary fashion and be considered equally important in the process of serving children and their families. The functions are distinct, but their contributions to treating the child are vitally needed. Group characteristics and management are discussed in the next section.

THE TCA UNIT COORDINATOR

Function. The individuals responsible for staffing cases will need to coordinate their efforts. The unit coordinator directs and facilitates the activity. The coordinator is responsible for:

1. facilitating screening meetings and convening group members to determine client eligibility based on agreed-upon criteria;

2. scheduling and coordinating case presentations; assigning each case to a worker and a specific time for the case presentation;

3. coordinating planning sessions by convening group members to discuss recommendations for service plans;

4. leading group activities; facilitating problem-solving, decision-making, and conflict management procedures; and,

5. fostering a team environment by ensuring that group members work as a team, meet regularly, and support each other in planning services.

Tasks. The unit coordinator ensures that information is appropriately distributed among group members and ad hoc members, parents, and significant others. The coordinator is responsible for ensuring that participants understand the goal of their collaboration, methods for operating as a unit, and maintaining group direction.

The coordinator assigns cases to planning unit members, who will serve as therapeutic case advocates and develop treatment plans. The coordinator makes sure that group meetings are recorded and that all relevant people are aware of meeting times.

After a case has been screened and determined eligible, the case is assigned to an advocate. The advocate is charged with gathering information and presenting the case to the group. This involves:

1. meeting with the child and family to determine the extent to which parents or parent surrogates will participate in the planning process. This information gathering includes conducting the initial assessment interview and making parents and others feel less intimidated by the group;

2. identifying members of the family's natural support network and formal provider network to determine the extent of their participation and support;

3. assessing the family and community for strengths and resources; and,

4. obtaining the necessary authorizations for release of information to obtain access to the child and family's records (e.g., IEP's, diagnoses, previous interventions, etc.).

The coordinator is able to conduct productive meetings by completing these steps prior to discussing the case as a group.

Coordinators will require experience with respect to group process skills, such as: problem-solving, decision-making, conflict management, and coordinating diverse individuals within a collaborative team to accomplish the necessary work.

THE TCA UNIT (Planning Unit)

Function. The TCA Unit is responsible for treatment planning and contains a core group of regular members, case-specific ad hoc or adjunct members, and the family of the children and youth. The unit meets on a regular basis to staff difficult cases.

The unit meets to perform functions vital to service planning, such as:

1. reviewing the child's previous diagnoses, therapeutic interventions, behavior, and interaction patterns;

2. identifying a range of therapeutic interventions and supports that can benefit the child and family;

3. developing advocacy, interpersonal intervention, and care management strategies that can enhance and broaden the scope of service delivery;

4. identifying and developing resources, services, and supports necessary to deliver comprehensive treatment; and,

5. proposing individualized systems of care and a mechanism for their management.

Both task groups (planning unit and service team) will need the flexibility to include parents, family members, adjunct members, and other individuals who have talents and skills important to these tasks. For example, meetings may include individuals who can offer cultural, ethnic or racial perspectives to ensure that treatment is culturally appropriate. In certain circumstances, it may be necessary to recruit some individuals as regular members because they provide a needed quality or factor for the group.

The unit is responsible for proposing initial comprehensive service plans for each child or youth presented to the group. The plans should suggest strategies for fulfilling specific goals. The unit may meet at times to revise the plan or discuss crisis management.

It is important for the TCA unit to have as much information as possible to ensure that treatment planning is relevant for children, youth, and their families. With this information, the TCA unit members can begin to understand:

1. the child's and the family's view of their problems, needs, and goals;

2. the child's and family's interpretation of the motives and actions of the workers and agencies that serve them;

3. the ways in which the child and family would change the situation, if they could; and,

4. the extent of participation by natural support networks in service delivery.

Tasks of the Unit. Information gathering is one of the tasks critical to the effectiveness of the TCA planning unit. Each case must be assigned to one of the unit members, who assumes primary responsibility in presenting it to the entire unit. The case presentation provides an opportunity for the entire unit to hear the issues; the presentation includes:

1. child and family histories (social, medical, psychological, and educational);

2. a review of previous diagnoses and interventions and their impact on the child's behavior or family stability;

3. a brief description of problems the speaker believes the unit needs to address; and,

4. additional information necessary before forming any perspective on the child's and family's situation, particularly strengths of the child, family, natural helpers, or community.

The narrative enables unit members to identify the range and scope of the problems to be addressed. A structured question and answer period follows to clarify any information discussed in the case presentation. The discussion is collaborative and at times, quite animated. Members offer input based on: (1) information gathered by the unit and (2) information learned during the case presentation. The unit can now consider designing a case level system of care and strategies necessary to implement their plans.

The unit discussion is essential to TCA because it allows the unit to:

1. identify specific individuals and environments that need to be included (and modified) in the system of care;

2. identify issues, problems, and goals to be addressed by the service delivery unit;

3. develop contingency plans for addressing case-related crises, problems, and emergencies;

4. identify or develop a range of treatment options, resources, and services as well as therapeutic supports for the child and family; and,

5. propose a comprehensive service plan that specifies individual responsibilities and timeliness.

THERAPEUTIC CASE ADVOCATE

The unit member assigned to present a case to the unit for screening is referred to as the *therapeutic case advocate* for that child and family. The advocate is responsible for gathering information, obtaining releases of information, preparing parents or family members for unit meetings, facilitating and monitoring the service plan, and managing the service team.

For support and guidance, the advocate can consult the unit. However, in some cases, certain matters can be delegated and guidance can be provided by both the family and service team members.

The basic duties of the therapeutic case advocate are outlined below:

1. Convene service team members and apprise them of their individual responsibilities and of the collective goal;

2. Ensure that communication exists between the TCA unit and the service team and between individual service team members;

3. Assist individual service team members in meeting their obligations, as specified in the treatment plan;

4. Assess the behavior settings and the individuals who routinely interact with the child to ensure consistency in expectations and in providing instruction, support and reward; and,

5. Foster a service unit environment that promotes honest communication, positive peer relationships, mutual support, and the capability to manage conflict.

To coordinate the effort, the coordinator of the service team needs to take the following steps:

1. Take the time to thoroughly understand the treatment plan in order to explain its reasoning capably;

2. Convene a meeting of the (potential) service team members identified in the plan, and:

   - introduce members
   - explain the goals of the plan
   - identify individual responsibilities within the plan
   - establish lines of communication between team members and between team members and the therapeutic case advocate
   - schedule future meetings;

3. Determine which (if any) service team members may require assistance in understanding or implementing aspects of the plan;

4. Monitor the child and family's response (progress) as it relates to the plan and report this to the unit; and,

5. Manage group interactions, including: problem-solving, decision-making, conflict management, and other group process issues.

THE TCA SERVICE TEAM

Function. The advocate (i.e., designated worker from planning unit) assembles the individuals who will represent the client when developing the case level system of care. The individuals representing the case-level system of care are referred to as the "service team." The service team is responsible for meeting the specific service needs of the child and providing these on a 24-hour basis.

The service team implements the planning unit's service plan and agrees to collaborate in serving the child and family. The team meets on a regularly scheduled basis to ensure that their efforts are coordinated and to identify any gaps in the case-level system of care.

The service team represents a variety of environments in which therapy is provided or supported. The service team constitutes a personal community that supports members in work that is very often demanding and frustrating. As a result, the concepts of teamwork and mutual support should be integral aspects of service team functions.

In essence, service teams do the day-to-day, direct work to meet the needs of the child and family. The team serves as the child's case consultant and advocate, and ultimately attempts to create environments suited to the child's and family's capabilities.

Tasks of the Service Team. Once the planning unit has reviewed the case and made service plan recommendations to the therapeutic case advocate, the advocate convenes the individuals involved in the case-level system of care. Recommendations are presented to prospective service team members, who in turn work with the advocate to implement or adjust the service plan.

The service plan will specify the role of each individual service team member. In some cases, the service team may need to modify or adjust the plan to meet the child's specific needs and attributes and to reflect the capability and purview of service team members.

The service plan contains several key features, including:

- the specific services provided by each individual or agency (including emergency or crisis situations);
- ways to modify behavior settings to best suit the child;
- the forms of instruction, support, and reward that are most effective for the child;
- time frames for accomplishing tasks;
- individuals who can augment the service team and strategies for securing their participation; and,
- the schedule for the next service team meeting.

In conjunction with the advocate, the service teams will meet to solve problems and address issues in implementing the service plan. In cases that involve higher levels of the organization or inter-agency efforts, the advocate may need to consult the planning unit.

The service team will have ongoing contact with the child and family and can identify the aspects of the plan that appear to be effective in working with the child. Service team members need to share this information to ensure that efforts are put in the same direction; individual members need to alert the team to emerging issues or behaviors.

The enablement plan (Figure 3) is a description of the work to be performed. It identifies the agency and person responsible, the goal or task to be performed, timelines to be established, and how the effort will be evaluated. It also serves as an accountability mechanism in that it details to the group the various individual responsibilities. Moreover, it prevents parents and relevant others for incorrectly finding fault or blaming a provider (formal or informal) unnecessarily. In cases where specific items were left unaddressed, the service team may be able to determine where a child and family fell through a crack, and perhaps how the crack can be filled.

The service team needs to collaborate periodically to keep members apprised of progress. Therefore, the service team will meet much more often than the planning units. The advocate must be familiar with group process issues and procedures to keep the service team focused and involved.

ENABLEMENT PLAN

_____ Date of Plan: _____

_____ Date of Review: _____

ency onsible?	By Whom?	By What Date?	At What Cost?	Source of Funds	Criterion	Follow-up?

Figure 3

SECTION III: THE THERAPEUTIC CASE ADVOCACY COMPONENTS

As discussed in Section II, the goal of Therapeutic Case Advocacy is to create and maintain an individualized case-level system of care for each child and his or her family. This section describes the specific components of the model, which is designed to promote collaboration in the creation of a nurturing environment for the child.

The three components of TCA are case advocacy, interpersonal intervention and care management. Each of the three components and the skills required to use them are presented, discussed and illustrated below. In general, however, case advocacy skills are used primarily to construct a case level system of care; interpersonal intervention skills are used primarily to engage and sustain the child, parents and others (i.e., helpers) in the process; and care management skills are used to coordinate and manage the system of care with respect to the changing circumstances and needs of the child and family.

Each component is guided by certain principles of action and includes a cluster of skills. On the following pages, three principles and ten skills are listed for each component. While the lists are not exhaustive, the skills listed are essential.

Component No. 1: Case Advocacy

PRINCIPLES:

1. The primary, over-arching goal is to create a case-specific system of care that surrounds and supports the child and his/her family on a daily basis.

2. The "targets" of case advocacy efforts are also human beings. Nothing is to be gained by declaring them enemies; advocacy can be partisan without being adversarial.

3. Child and family involvement in all aspects of the advocacy process is essential to enhancing their capacity to advocate for themselves.

SKILLS: To be able to...

1. identify "target areas" within an ideal system of care.

2. define the resource development task for each behavior setting encompassed by the system of care.

3. for each behavior setting, locate individuals who could provide alternative instruction, support and reward for the child and/or family.

4. acquire the history of previous interactions between child/family and potential providers.

5. use the process of assessing the discrepancy between the child's/family's needs and current services to forge a personal relationship with the provider.

6. analyze the "price structure," for mobilizing the modified set of instruction, support and reward for each behavior setting.

7. specify your basis for leverage in the situation.

8. consider the effect of timing on the success of your request to provide alternative instruction, support and reward.

9. formulate and prepare contingency plans in the event that the alternatives provided provoke a crisis between child/family and provider.

10. persuade potential provider to try alternative instruction, support and reward.

Component No. 2: Interpersonal Interventions

PRINCIPLES:

1. The primary, over-arching goal is to engage and sustain the child and family in the process of accommodating to their environment.

2. Interpersonal interventions are carried out to serve case advocacy and management efforts to establish and maintain a system of care, not vice-versa.

3. The use of interpersonal interventions is not synonymous with providing psychotherapy. These skills are necessary in working with the client and with others in the client's environment.

SKILLS: The ability to...

1. "listen with a third ear" for issues that others would like to discuss, but feel they cannot.

2. absorb verbal abuse and aggression in response to the offer of help.

3. understand and describe one's own feelings directly.

4. acquire an empathic comprehension of another person's difficulties and convey empathy in both words and gestures.

5. translate a person's psychological needs into plans for enhancing, restructuring or modifying his/her environment's provision of instruction, support and reward.

6. clarify one's own role and the purpose of the relationship, which is to design and establish a system of care.

7. separate a larger problem into manageable but meaningful tasks.

8. encourage feedback on the helpfulness of the relationship and the process of accomplishing tasks.

9. anticipate the demands of new accommodations on children, their family and others in their environment. Devise opportunities for respite and reward as part of the process of constructing the system of care.

10. set enforceable limits on the behavioral expression of anxiety, impatience, frustration or anger; negotiate the consequences for exceeding those limits.

Component No. 3: Care Management

PRINCIPLES:

1. The primary over-arching goal is to coordinate, integrate and maintain a network of services to establish and support a functioning balance between child, family and their environment.

2. The guiding idea behind care management is development of an individualized system of care that remains flexible and adaptive to changing needs and circumstances. Accountability, therefore, is ultimately to the child and family.

3. The *process* of care management is more important than the product. By definition, the process is individualized, interactive and pluralistic.

SKILLS: The ability to...

1. assemble the individuals involved in each of the child/family's behavior settings to design the system of care and determine each person's contribution (the TCA service team).

2. involve the child and family in this process and verify mutual understandings and expectations.

3. define goals to use in evaluating progress for each component in the system of care.

4. select a care manager from among the members of the TCA service team.

5. review plans for modifying the provision of instruction, support, and reward in each behavior setting. Establish a time/task chart specifying the individual/agency responsible for the task and deadline for completion.

6. schedule meeting time(s) and place(s) for subsequent reviews and modifications of the instructions, supports and rewards.

7. devise measures of satisfaction with the system of care for completion by the child, parents and each of the members of the system of care.

8. devise a system of 24-hour response capability for crisis intervention, preferably rotating responsibility among team members.

9. create support system(s) for providers in the system of care.

10. evaluate the adequacy of the system of care from the consumers' and providers' perspectives.

DIRECT WORK WITH CHILD AND FAMILY

At the case level or in direct work with the child and family, interpersonal interventions may be necessary to help the parents overcome feelings of frustration, failure, hopelessness, anger and resentment to consider the resources available through their own "personal community" of friends, neighbors, relatives and other networks of natural support. Direct personal intervention may be necessary with the child to help him or her overcome feelings of distrust, fear, resentment and anxiety and to become an active participant in designing the system of care.

Advocacy may be needed on the child's behalf vis-a-vis the parents, and vice versa. Children with emotional disabilities and their parents are often sources of frustration, disappointment and anger for each other. Explaining the perspective and needs may be an initial step needed to work together. However, the Therapeutic Case Advocate will usually speak for the entire family to representatives from other organizations, such as law enforcement agencies, child welfare departments, mental health clinics, juvenile courts and churches. The purpose of advocacy is to persuade others to collaborate in developing and sustaining a system of care for children and their families.

In discussing the "child and his parents," other family members must also be included, as architects and beneficiaries of the system of care. Bear in mind the "family" can be viewed as nuclear or extended. In keeping TCA culturally compatible, the "family" or "parents" must be defined in terms of the child's, parent's, or community's culture. For example, day care for younger siblings, after school recreational programs for siblings, service center involvement for an elderly grandparent are all elements in a system of care that would make daily life more manageable for both the child with emotional disabilities and his or her parents. (Explicit reference to other family members in the following discussion is omitted for the sake of brevity. Each reader must extend the model's components to the entire family relative to how family is viewed in a given cultural context.)

Care management at the case level means repeated evaluation and modification of the system of care. This process is pluralistic by definition. This means that the child, parents, other family members and the participants from the formal system and natural support networks meet periodically to assess the system of care. Inevitably, the configuration of the system of care will change over time as the child's and family members' needs or circumstances change.

In applying case advocacy, interpersonal interventions, and care management to direct work with the child and family, there are four characteristics of each behavior setting that must be examined: the expectations, instructions, supports and rewards provided to the child. If these are not compatible with the child's present goals, ambitions, talents and evolving skills, the setting is contributing to the child's emotional disability (Kohut, 1980). A setting is made less disabling and disturbing to a child by offering expectations based on the child's ambitions, support in attaining goals, instructions based on talents and skills, and rewards for each attempt to improve skills.

THE ORGANIZATIONAL LEVEL

At the organizational level, case and advocacy skills may be used in seeking exceptions to administrative rules and regulations to obtain the resources necessary to support the system of care. For example, one worker appealed her agency's ceiling on foster care payments so that a foster father could spend more time at home in the late afternoon helping an adolescent with an emotional disability with his school work. The worker's success was based on her ability to demonstrate that the foster father could not take time off from work without the increased foster care payment. Consequently, the child would have had to attend a day treatment program, at much greater expense to her agency.

Interpersonal intervention skills also can be useful at the organizational level. In the case example above, the worker used the meeting with the planning unit to identify her own frustration with the agency's policy and the cumbersome appeal process. The unit helped her redirect her frustration into formulating a strategy for appeal. She was able to elicit her supervisor's support by recognizing his personal reluctance to take action.

Applying care management skills at the organizational level requires a commitment to the system of care concept and a tolerance for change over time. The system of care concept involves collaboration to coordinate activities, review progress against desired goals, and modify actions in response to changing needs.

The mechanics of care management can become tedious and burdensome if considered mere paperwork (e.g., multiple telephone calls to arrange meeting times, locating suitable and accessible meeting space, preparing progress reports.) It is important to involve other members of the organization in the process, particularly in large agencies. This enhances the caring aspects of the enterprise and makes the organization's response to unanticipated crises more human.

THE INTERAGENCY LEVEL

By engaging the child and family in defining the elements needed in the system of care, developing support within the agency, the support and collaboration of workers from other agencies can also be obtained. Collaboration is a welcome change to the burden of sole responsibility for a complex situation often without adequate resources. Most staff know too well that their clients' needs exceed agency services and resources.

In initiating interagency collaboration, the three components of the model can also be applied. Case advocacy and interpersonal skills may help persuade directors of other agencies to permit their staff members' participation. The initiating worker may have to apply these skills at the case and organizational levels. The issue for the worker may be a fear that the agency might be embarrassed or harmed in this collaborative process. At the supervisory/administrative level, the initiating worker may discover that staff participation requires written assurance that this is an approved activity and is intended to minimize or eliminate duplication and service effort.

Care management skills at the interagency level may help sustain the system of care by saving agencies' time and money. The initiating worker may use the care management skills to monitor and sustain participation. The care management component of Therapeutic Case Advocacy extends beyond the child and family to formal and informal helpers.

SECTION IV: TCA GROUP PROCESS ISSUES

The planning unit and the service teams are task groups. Using multidisciplinary task groups to provide children's mental health services can be difficult. But task groups create the coordination and collaboration indispensable to providing comprehensive services of high quality. Unstructured task groups may disband at first conflict or perform inefficiently. Therefore, planning unit or service team members need to understand how their groups will operate prior to staffing cases.

Two objectives are critical in utilizing the model:

1. **Accomplishing the work** - the group must be organized to perform the work and secure the necessary resources (e.g., time, information, leadership, communication, etc.); and,

2. **Maintaining the group** - the social and emotional needs of unit and service team members must be addressed.

To assure that these requirements are met, unit members should understand how the group will function. The group will need to address issues of membership, accountability, meeting places and times, and procedures. Initial discussion among prospective unit members should address several issues, such as:

A. **The Purpose of Forming the Unit**

Discuss the purpose among unit members:

- to coordinate service delivery for children and youth with serious emotional disabilities and their families
- to involve families and their natural networks of support in the planning of treatment and service delivery
- to establish client-centered systems of care for children and their families
- to develop comprehensive service plans in collaboration with a variety of provider agencies

B. **Unit Activities and Procedures**

Establish formats for the items below and discuss as a group:

- intake criteria
- case presentations
- service planning
- resource development
- accountability
- evaluation

C. **Group Cohesiveness**

- unit administration and supervision
- providing support to colleagues
- preparing for meetings
- sharing information
- communicating honestly
- listening to others
- supporting the group decision

The three most common activities involving planning unit or service team members are problem-solving, decision-making and managing conflict. Problem-solving procedures are needed to help the task group develop a range of potential solutions or approaches to address a particular issue. After generating a range of solutions, decision-making procedures are often necessary to select a course of action or approach. Conflict management procedures are essential for dealing with intra- and inter-group tensions and disagreements, which appear inevitable when individuals of diverse backgrounds, personalities, and beliefs work together, possibly for the first time.

This section discusses the procedures and approaches that must be practiced and refined to enhance the efficacy of the TCA unit and service team.

PROBLEM-SOLVING

Problem-solving activities occur after the case has been presented and the major issues have been identified. It may be easier to address large problems by separating them into smaller parts. Outlined below is a three step approach to problem-solving:

Task 1: Problem-Solving

Step 1: Identify and Define the Problem

- Identify the problem(s) to be addressed by the unit.
- Define the issue(s) associated with each problem.
- Ensure that members clearly understand the issues so that potential solutions can be generated.
- Identify problematic behavior settings.
- Identify individuals in various behavior or treatment settings and their success with a particular child or family.

Step 2: Develop a Range of Possible Solutions

- Develop a range of possible solutions.
- Identify child-, family-, culturally-, or community-based strengths.
- Use brainstorming to stimulate ideas and help the group decide.
- Defer critical analysis until range of possible solutions is exhausted.
- Ensure that everyone has had an opportunity to voice concerns and offer suggestions.

Step 3: Assess the Proposed Solutions

- Develop details for the options identified in step 2.
- Prioritize the approaches in terms of addressing the most critical needs.
- Critically examine the solutions proposed in step 2.
- Narrow the range of solutions and collaboratively select the most promising option(s).
- Note the options that were not utilized, for future reference.

DECISION-MAKING APPROACHES

The problem-solving task may result in two or more viable options, from which the unit must select only one. The unit must anticipate that a variety of problem-solving methods may be needed, yet one option must be chosen that the entire unit will support. Several possible approaches are identified below for promoting decision-making among a range of viable alternatives:

Task 2: Decision-Making Approaches

Approach # 1 Building Consensus

- the most time-consuming, yet commonly used method
- requires an environment conducive to individuals listening to the ideas of others
- invites analytical discussion of options
- promotes cooperation by allowing members to voice their concerns; increases support for the group's decisions
- may be difficult to obtain when several options appear viable

Approach # 2 Simple Majority Vote

- is the quickest and most commonly used approach
- tends to ignore minority viewpoints

- may split the group into winners and losers
- eliminates analytical discussion, resulting in weaker solutions
- increases likelihood that the group will develop pat responses to different situations

Approach # 3 Two-Thirds Or Three-Fourths Majority Vote

- a blend between consensus and majority vote
- quicker process than building consensus, yet protects a strong minority perspective
- use when time is short
- use when consensus is impossible to reach

Approach # 4 Delegated Decision-Making

- use in less important issues, or when a quick decision is required
- unit members delegate authority to make a decision to a specific person
- eliminates analytical discussion

Approach # 5 Repeated Voting
(involves repeated balloting until the range of options has been narrowed down)

- narrows the field of options prior to using other decision-making approaches
- voting is repeated until those options that receive limited support drop from consideration
- use only when a large number of options have been generated

Approach # 6 Averaging Individual Opinions

- used when time is short and all unit members are not available for consultation
- poll individuals and ask their position and how they intend to vote
- may not receive support from those not polled
- eliminates the possibility of group discussion
- is recommended for less important matters

In some cases of absolute deadlock, a predetermined figure (e.g. advocate), should be responsible for rendering a decision. Nevertheless, this decision should be treated as a group decision and supported in earnest.

IMPLEMENTING THE PLAN

The case presentation, problem-solving and decision-making activities will conclude in the development of a comprehensive plan. The plan should outline the case level system of care, identify the designated worker, suggest the components to be used to execute the plan, and provide an indication as to the individual or agency

responsible for providing each resource or service to the child and family. The plan should also suggest methods for providing accountability and timeliness for case evaluation.

The plan should specify the individuals to include on the service team and the possible steps to take to secure their involvement. Also, the plan should outline the ways in which various behavior settings in the child's environment should be modified and methods for monitoring and evaluating those modifications. Steps to the implementation process are outlined below:

Task 3: Implementing The Service Plan

Step 1: Assemble Prospective Members of the Service Team

- introduce service team members
- discuss how and why each member has been selected for the service team
- identify the major goal(s)
- determine or solicit their support

Step 2: Approve the Service Plan

- review the unit's recommendations
- identify issues, problems or other factors overlooked in the recommendation
- develop approaches that reflect the capability of the service team
- obtain input from all service team members
- inspect the plan for gaps in the system of care
- approve the plan

Step 3: Discuss Individual Assignments (See Enablement Plan, Figure 2)

- explain individual assignments in relation to the overall goal
- explore the type of environment most likely to elicit the best behavior and performance from the child, based on input of all service team members
- ensure that all members know the expectations for the child and the instructions, supports, rewards to provide
- develop timelines and checkpoints for monitoring the plan's impact on the child and the behavior settings in his or her environment

Step 4: Execute the Plan

- ensure that team members understand their assignments
- inform team members that the worker or the team is available for support or guidance as needed
- establish regular meeting and review times

- identify a method for service team members to contact the advocate in the event of unforeseen problems
- distribute a telephone list of service team members
- develop and issue phone lists of all back-up providers who will support the child and family during crises or emergencies (e.g., respite provider, crisis counselor, etc.)

MANAGING CONFLICT

The goal is to manage conflict instead of simply resolving it. Conflict typically conjures up negative images and leads many people to avoid it, ignore it, or placate those embroiled in it. However, the issue or basis of the conflict will emerge again.

By managing conflict, it can be brought into the open so that it is validated, legitimized, and receives necessary attention. Conflict should be viewed as a natural consequence of important relationships and amenable to management through coordinated communication.

In managing conflict, the first goal is to clarify the conflict by: tracing its roots, providing an environment conducive to discussion, having relevant parties define the issue from their perspective, and cutting through the multiple issues. Secondly, the goal is to develop a mutual understanding of the problem to move toward a solution that is acceptable by all.

Conflict is a potential factor when convening any group that engages in difficult or important work. The potential for conflict increases when group members are diverse or when they fail to recognize their common attributes or goals. Whether conflict runs a destructive or constructive course depends on the unit's skill and preparation in managing it.

For TCA, four basic steps are required to manage conflict:

1. Identify the conflict or potential conflict,
2. Assess the conflict situation and develop a range of possible solutions,
3. Select an appropriate strategy,
4. Implement the desired strategy.

Identifying the source of the conflict and developing appropriate interventions are critical steps. Conflict may stem from a variety of factors (e.g., personality, status, education, etc.). Once the source has been identified, intervention strategies can be developed.

Structural and *interpersonal* strategies can be used alone or in combination to manage the conflict. Examples of structural approaches include:

1. Reorganizing work responsibilities;
2. Modifying unit operating procedures;

3. Adjusting caseload size or type;

4. Restructuring the physical plant or changing the meeting site; and,

5. Modifying meeting times.

Structural approaches involve an examination of objects, practices or policies that may be difficult to modify. Yet this can be essential in promoting group cohesion and maintenance.

Sometimes conflict will not involve a structural issue and may require an *interpersonal* strategy. Bargaining and negotiating are particularly useful when conflict involves scarce resources that can be divided or provided alternately to the conflicting parties. Satisfactory solutions regarding the use of space, funds, clerical support or equipment can be achieved this way.

Combining structural and interpersonal approaches may be most effective in conflicts involving differences in work-related beliefs and values, unit goals and practices, and other aspects of work within the TCA unit. In situations where members' values or beliefs are contradictory, efforts to manage conflict may be directed toward forging a peaceful co-existence.

The effective management of conflict demands creativity, persistence and courage. Anticipating and preventing conflict through structural or interpersonal strategies appears to be the most viable approach.

This section did not address all group processes relevant to the planning unit or the service team. The basic procedures were presented to make the model operational and the task groups (i.e., the unit and the service team) more effective.

As suggested, unit coordinators and therapeutic case advocates need experience with group management techniques. In many instances, additional procedures may be identified to enhance the group's performance and efficiency.

SECTION V: EVALUATION ISSUES AND TCA

The TCA model should be evaluated for its impact on the life of each child and family, and to identify areas in which the model can be improved. This section will explore some of the issues associated with evaluating the model and contains some sample data collection instruments. The instruments and recommended procedures for their use can be found in the TCA Trainer's Manual.

PROCESS AND OUTCOME EVALUATION

Evaluating the practice of TCA must incorporate *process* and *outcome* measures. Process refers to an analysis or study of the steps involved in the course of service delivery, or the "mechanics" of the model and how well it operates. Without such information, it becomes difficult to replicate or refine the approach. Further, this analysis identifies specific steps that could be taken to improve the model.

Outcome refers to the analysis of the results of the TCA interventions. It essentially examines the child's and family's quality of life and the ways in which interventions have affected their lives. In some cases, traditional measures of pre-post functioning may be appropriate. With some children, however, no change in behavior or functioning may be a positive outcome, particularly if an out-of-home placement was prevented, the child's return to the community was expedited, or the child is at less risk than before.

Other outcome measures may be based on fiscal considerations, such as savings in funds or in a worker's time and effort. Some measures may be based on the perspectives of the parent, child, family, or community.

If consumers are not part of an evaluation scheme, then process or outcome measures may only address agency or practitioner concerns and inadvertently overlook the impressions of children and their families.

Another important aspect of evaluation involves the feelings of members of the planning unit or service team. Again, measures of both process and outcome may be important.

The object of evaluation is to discern the effectiveness of the approach, the impact on children, youth, and their families, and the impressions of the diverse professionals and individuals who are involved in the client's care.

The model is multi-level, case-specific and collaborative. It can benefit individual children, their families, and even the agencies working on behalf of children and youth with emotional disabilities. It can also benefit these children when: barriers to services are identified, documented and removed; policies and practices are examined and revised; or greater collaboration and coordination occurs between relevant agencies.

CASE AND CLASS ISSUES

At the case level, evaluation can address the following questions: Does the model serve some children well and not others? How does one account for the differences? What issues are dealt with on a case basis that have relevance for all children? What are the breakthroughs on a class basis and what relevance does it have for the individual?

Certain individuals participating in TCA (particularly service team members) will be involved on a *case specific* basis and will be associated with one case. These individuals include: the parent or family of a child or youth; service team members; members of the family's natural networks of support; and the child or youth. In most instances, service team members may be able to comment on only one case. The individuals involved in class issues include: the unit coordinator and/or supervisor; TCA unit members; and members of TCA service teams who belong to more than one client's case level system of care.

EVALUATION ISSUES FOR PLANNING UNIT MEMBERS

Planning unit members will be involved in many activities, including: screening and intake; reviewing client histories and other records; attending case presentations; proposing solutions to problems; developing recommendations for individualized service plans; and creating effective systems of care at several levels. Unit members will be multi-disciplinary and will involve and support parents in planning treatment and service delivery. Unit members will staff all cases that will receive TCA services. Thus, the way in which this group conducts business and orders their interactions will be very important to evaluating the model. From a process standpoint, issues may be examined such as:

- the types of administrative support that are most useful to TCA planning units;
- the characteristics of cases that were not accepted by the planning unit;
- the quality of the solutions proposed through planning unit discussions;
- the degree to which parents were involved in planning unit activities;
- the strategies developed for soliciting support and cooperation from other agencies and organizations; and,
- the degree to which unit members understand group procedures, practices, and objectives.

There will also be some interesting outcome measures associated with the TCA planning unit. Some of the information that may be useful includes:

- the unit's ability to identify practices and policies in their own agencies or other agencies that need changing to benefit the client(s);

- the unit's ability to design and utilize advocacy approaches, interpersonal interventions, and care management strategies to facilitate comprehensive service delivery; and,

- the unit's ability to create comprehensive service plans collaboratively that involve the support of natural helping networks and formal providers.

EVALUATION ISSUES FOR SERVICE TEAMS

The service team is essentially the case-level system of care for individual clients. Team members are responsible for implementing the treatment plan with the coordination of the designated advocate. Team members will either provide services or have contact with the child on a regular basis. Aside from the parents, service team members will be the sensory apparatus of the planning unit; they will be able to monitor the child's behavior, assess the suitability of environments, implement modifications, and report any emerging issues or factors in a given case.

Most service team members will be associated with only one child and family. The nature of their interaction is case-specific and they can comment only on their experience as it relates to one child. Evaluating service teams from a process perspective can yield information pertaining to:

- the quality and style of communication and interaction required to establish effective service teams;

- the degree to which service teams were able to operationalize the planning unit's service plan;

- the service teams' ability to identify issues or problems overlooked in the planning unit;

- the types of members, agencies and organizations represented on a child's service team (as well as those that are not represented but should be);

- the extent to which service team members collaborate and are mutually supportive;

- the degree to which information is shared between service team members; and,

- the degree to which service team members help each other fulfill specific obligations outlined in the service plan.

Outcome measures promote confidence with respect to our interventions. It is important to measure the benefits that accrue not only to the child and family, but also to the individuals, professionals and agencies working on their behalf. Surveying the service team provides relevant information, including:

- the difficulty experienced by the service teams in comprehending the planning unit's service plans;

- the degree to which the advocacy strategies, interpersonal interventions, and care management techniques were beneficial;

- the amount of support and guidance service team members provide each other in carrying out specific goals;

- the effects of environmental modifications on a child's behavior;

- the degree to which children and their families felt the system of care was able to meet their needs;

- the degree to which service team members were consistent in their expectations of the child and in providing instruction, support, and reward; and,

- the degree to which expertise in the planning unit could be used to help service team members carry out their individual objectives, as outlined in the treatment plan.

EVALUATION ISSUES AND THE THERAPEUTIC CASE ADVOCATE

Advocates are assigned to a child and family and are responsible for coordinating the activity of the service team. The advocate, when necessary, consults with the planning unit for assistance in implementing the service plan. The advocate participates in the planning unit sessions and develops recommendations for the service team. The advocate is responsible for ensuring that communication takes place between service team members and between the service team and the planning unit.

The advocate is a key individual in evaluating service team dynamics. Process measures that may be important include:

- the difficulties encountered in fostering a team concept among service team members;

- the degree to which service teams were properly staffed to carry out the objectives; and,

- the degree to which the planning unit was able to assist the advocate in supporting service team members through difficult assignments.

The outcome measures that will be of interest include:

- the extent to which service plans were implemented;

- the degree to which environmental modifications were made in accordance with the service plan;

- the timeliness and coordination of communication between service team members and between the unit and the service team;

- the degree to which service team members needed help in understanding their role; and

- the degree to which individual service team members were able to access the advocate to report relevant information or to inform the unit that a plan has not been successful.

PARENTS AND FAMILY EVALUATION ISSUES

Beginning at the initial planning meeting, parents are included in planning service delivery for their child. Parents (biological, foster, adoptive, or surrogate) can offer planning unit members a wealth of knowledge about the child, such as: previous behaviors, diagnoses, and interventions; the barriers parents have encountered in trying to secure the best treatment for their child; and resources and services that would be of most value to them. The parent's firsthand experiences with the child might also be illuminating to the unit members in identifying the child's, family's, community's or cultural group's strengths.

From a process standpoint, a great deal of information may be obtained regarding the ways in which a TCA planning unit can utilize and benefit from parent involvement. This may enhance understanding of:

- the degree to which planning unit members were able to accept parents as peers in planning service delivery;

- the desire and willingness to participate on the part of parents;

- the types of barriers the planning unit encountered in getting parents to meetings;

- the willingness of professionals to interact with parents as a matter of policy and practice under TCA;

- the parent's ability to understand how the model is to operate and how they can support the plan; and,

- the degree to which parents felt their concerns were actually being heeded by unit members.

From the perspective of parents and families, some of the outcome measures should address:

- the degree to which parent-professional collaboration led to a more comprehensive and relevant service plan;

- the methods of enhancing the parent's competence in advocating for their child;

- the unit's ability to help parents understand fiscal and legal constraints under which many well-intentioned workers and agencies operate; and,

- the degree to which parents clearly understand the behavior and the objectives of interventions as a result of parent-professional collaboration.

CHILDREN AND EVALUATION ISSUES

The child's role in TCA is typically that of a consumer. Some children will be able to describe the benefits and drawbacks to the model. Age, maturity, the nature of the disorder, and other factors will largely affect our ability to elicit accurate information from any given child. However, when possible, methods must be devised to get as much valid and reliable information from the child as possible.

There are some general issues which children and youth can address, for example:

- the perceived differences in others' expectations of them and the ways in which instruction, support, and reward are currently provided;

- helpfulness of their relationships with service team members;

- the degree to which their service team contained members with whom they could consult on an informal basis;

- the degree to which they found the environmental modifications helpful; and,

- the accessibility of the service team members.

This is not a comprehensive examination of evaluation issues; however, it describes some of the issues to be addressed. More importantly this discussion specifies some of the measurements that can be collected and analyzed to evaluate the model's efficacy and to discover areas in which the model or practice can be improved. Please see the Trainer's Guide for some suggested formats for evaluative data collection forms.

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THERAPEUTIC CASE ADVOCACY WORKERS' HANDBOOK

EVALUATION FORM

1. Who used the *Therapeutic Case Advocacy Workers' Handbook*? (Check all that apply.)

   ___Parent ___Educator ___Child Welfare Worker

   ___Juvenile Justice Worker ___Mental Health Professional

   Other (Please Specify)_____

2. Please describe the purpose(s) for which you used the *Workers' Handbook*:

   _____

   _____

   _____

3. Would you recommend use of the *Workers' Handbook* to others? (Circle one)

   Definitely Maybe Conditionally Under No Circumstances

   Comments:_____

4. Overall, I thought the *Workers' Handbook* was: (Circle one)

   Excellent Average Poor

   Comments:_____

5. Please offer suggestions for the improvement of subsequent editions of this *Workers' Handbook*:

   _____

   _____

   _____

   _____

   _____

We appreciate your comments and suggestions. Your feedback will assist us in our effort to provide relevant and helpful materials. Thank you.

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